

## Good Provider, Good Patient: Changing Behaviors to Eliminate Disparities in Healthcare

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We examined the relationship between cross-cultural provider-patient interactions and health outcomes through a literature review. Results were presented in the form of guiding principles to an expert panel of health care administrators, medical practitioners, and medical care providers. This expert panel met at the workshop "Changing Patient Behavior" during a conference convened by the office of Minority Health, US Department of Health and Human Services, February 17-18, 2000. The panel reviewed the themes and formulated suggestions for program and policy change. Six principles were identified: (1) Physicians should acknowledge that patients may be actively involved in health maintenance long before they seek medical care. (2) Patients should be empowered to be active participants in their medical care. (3) Providers should critically evaluate their own assumptions and underlying values about what constitutes a "good" patient and consider how these assumptions and values affect their communication strategies. (4) The patient's behavior change in the medical interaction should result from a process of negotiation between provider and patient. (5) The medical system should focus on community empowerment in addition to individual empowerment. (6) Accessible and understandable health outcome data will empower the community to participate in the elimination of health disparities.

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One of the two overarching goals for *Healthy People 2010*, the national disease prevention and health promotion agenda for the year 2010, is to eliminate health disparities among different segments of the population, including racial and ethnic disparities.<sup>1</sup> The elimination of racial and ethnic health disparities in access to healthcare services also is a priority for the US Department of Health and Human Service's 5-year strategic plan.<sup>2</sup> These stated goals and priorities are supported by reports from the Institute of Medicine, Physicians for Human Rights, and other organizations that African Americans and Hispanic Americans (and to a less well documented extent, American Indians, Alaska Natives, Asian Americans, Native Hawaiians, and Other Pacific Islanders) receive less medical care in general, and less intensive care than comparable white patients.<sup>3</sup> This pattern has been found for use of high-technology interventions such as angioplasty and coronary artery bypass surgery, for more general medical and surgical procedures, and for treatment of chronic conditions such as diabetes.

While other papers in this issue focus on required system and policy changes to address these disparities, we explore the role of effective patient-practitioner communication in achieving this goal. What constitutes a "good" provider and a "good" patient? What should a provider do to achieve patient behavior change? How should the patient be involved in the treatment process? Universal access to healthcare is a principal factor in the elimination of racial, ethnic, and class disparities in health outcomes. However, equal access to healthcare does not ensure equal treatment of patients of differing racial, ethnic, linguistic, or socioeconomic backgrounds.<sup>4</sup> As was long ago noted by medical sociologists, in both the provider-patient interaction and the medical community-patient community interaction, the patients are inherently unequal because the medical institution holds the economic power and the technical medical expertise.<sup>5,6</sup> This inequality often is magnified when the patients and providers are of different racial, ethnic, or socioeconomic backgrounds.

Given the complexities of each patient's medical needs, differential treatment caused by provider biases and stereotypes is difficult to identify. However, a growing body of evidence shows the influence of sociodemographic variables such as race/ethnicity, education, and income on provider-patient communication and medical care decisions that ultimately influence health outcomes. Several studies have identified groups at risk for suboptimal interpersonal care. For example, after adjusting for severity of illness and patient preferences for care, patient sociodemographic factors were found to be strongly associated with receiving care among patients with an acute exacerbation of congestive heart failure. Patients were significantly less likely to receive care from a cardiologist if they were black, had a low income, were not well educated, or were older than age

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80 years.<sup>7</sup> In one of the few standardized experiments using actors as patients, black “patients” who presented the same symptoms (chest pain) and had the same sociodemographic characteristics as white “patients” were less likely to receive referrals for cardiac catheterization (female “patients” also were less likely to receive referrals than male ones).<sup>8</sup>

Studies have suggested an overall need for physicians to improve communication skills with all patients.<sup>9</sup> Patient characteristics such as age, ethnicity, sex, and appearance were found to independently influence physician behavior during the clinical interview (interviewing, nonverbal attention, courtesy, information giving, and empathy).<sup>10</sup> Communication between patient and physician about undefined cardiac problems was found to be less effective when the patient was of lower socioeconomic status.<sup>11</sup> The differential communication styles influence whether or not physicians involve patients in decision making. In a telephone survey of 1816 adults, African American patients rated their visits as significantly less participatory than whites in models adjusting for patient age, sex, education, marital status, health status, and length of the patient-physician relationship. Patients in race-concordant relationships with their physicians rated their visits as significantly more participatory than patients in race-discordant relationships.<sup>12</sup>

In the baseline cross-sectional survey of the Medical Outcomes Study, Kaplan et al identified several patient and visit characteristics that maximize or compromise the participatory decision-making style in the provider-patient interaction.<sup>13</sup> Patient-provider interactions that had the least participatory decision-making styles were those involving patients who were elderly (age 75 years and older), were young adults (age 30 years and younger), had low educational levels (high school diploma or less), were members of a minority group, and were male. Male patients seeing male physicians had the least participatory visits compared with male patients seeing female physicians or with female patients seeing physicians of either sex. The participatory styles increased with the duration of the physician-patient relationship. Language congruence between patients and physicians was found to directly affect health outcomes. After controlling for age, education, sex, and health status, Latino patients whose physician spoke the same language had better physical functioning, psychological well-being (anxiety and depression subscales), and health perceptions (current health outlook and distress subscales), and less pain.<sup>14</sup>

Language discordance also was found to negatively affect patient satisfaction, willingness to return to the same emergency department if emergency care was

needed, and patient-reported problems with care, communication, and testing.<sup>15</sup> David and Rhee reported that Latino patients with limited English proficiency were significantly more likely to report that side effects were not explained, were less satisfied with medical care, and were less likely to think that their doctors understood how they were feeling.<sup>16</sup>

In the medical interview, decreased diagnostic powers as a result of impaired communication between a clinician and patient may cause physicians to defensively order unnecessary, hazardous, or expensive diagnostic tests, or may make physicians less likely to order needed tests.<sup>17</sup> Patients who do not understand their physicians are less likely to take medication as directed, follow instructions, and keep medical appointments.<sup>18,19</sup> For example, asthma patients with language-discordant physicians were more likely than those with language-concordant physicians to omit medication, miss office appointments, and make at least 1 emergency room visit.<sup>20</sup> Additionally, language barriers impair shared decision making between patient and physician, making informed consent, for example, difficult.<sup>17</sup> In addition to race and language, ethnic and cultural factors may affect the ways in which the physician must communicate in the medical interview to improve both physician and patient satisfaction with the medical encounter.<sup>21</sup> Studies on Asian American populations suggest that ethnic background, language barriers, cultural beliefs, socioeconomic status, and distrust of Western medicine have contributed to difficulties in providing care to these populations.<sup>22</sup> A culturally sensitive medical interview may require physicians to use different communication strategies to understand and explain the illness experience of the patient.<sup>23(p153)</sup>

In Mexican, Cuban, and Puerto Rican communities, the patients may expect the medical interview to be a familial interaction with minimal harsh criticism from the physician.<sup>24</sup> For some Chinese and South Asian patients, it may be culturally appropriate to express emotional distress in terms of physical symptoms; thus, the behavior of these populations may not be a psychosomatic illness, but an expression of personal problems.<sup>23</sup> Pain complaint is a behavior that varies by ethnicity: Italian and Jewish immigrants may express their pain passionately, while Native Americans and Southeast Asians may be more restrained in their pain expression.<sup>23</sup>

The unequal treatment of patients belonging to diverse racial, ethnic, and socioeconomic groups poses several questions to the provider community. What is at the root of this unequal treatment? Is this treatment partially the cause of the unequal outcomes that we

see? How do we educate patients about the culture of medicine so that they may “demand” their just treatment? How do we institutionalize change when the medical system does not work to provide equal care to members belonging to diverse racial, ethnic, or socioeconomic groups? How can we empower and activate the patient and his or her community?

In short, how can we ensure that the patient is an active partner in the provider-patient interaction? It is important that the patient’s opinions, attitudes, and preferences be solicited and taken seriously even if the provider does not agree with them.

#### GUIDING PRINCIPLES FOR PROVIDER-PATIENT INTERACTION

The following 6 principles address the challenges of changing patient behavior.

1. Physicians should acknowledge that patients may be actively involved in health maintenance long before they seek medical care.
2. Patients should be empowered to be active participants in their medical care.
3. Providers should critically evaluate their own assumptions and underlying values about what constitutes a “good” patient and consider how these assumptions and values affect their communication strategies.
4. The patient’s behavior change in the medical interaction should result from a process of negotiation between provider and patient.
5. The medical system should focus on community empowerment in addition to individual empowerment.
6. Accessible and understandable outcome data will empower the community to be active participants in the elimination of health disparities.

#### Physicians Should Acknowledge That Patients May Be Actively Involved in Health Maintenance Long Before They Seek Medical Care

Health promotion is a “process of enabling people to increase control over and to improve their health. . . .”<sup>25</sup> However, health promotion frequently is not conceptualized in this broader framework. A frequent comment from Western-trained providers is that consumers “are not used to preventive medicine,”<sup>26</sup> implying that their health behavior is more oriented toward the management of diseases rather than the promotion of health.

This statement ignores the fact that patients may have very different strategies for deciding when and where to seek advice and treatment, and that they make choices based on their priorities, previous healthcare experiences, cultural values, and socioeconomic envi-

ronment. For example, community members may play an active role in health promotion by eating or avoiding certain foods, striving to keep a balanced lifestyle, or using herbs or vitamins to strengthen the body. Some may visit the medical system only when these health promotion behaviors and treatment with nonallopathic medicine are insufficient to deal with major illness episodes.<sup>27</sup> Western-oriented health providers often do not consider the role of alternative medical treatments and lifestyles in consumers’ health maintenance and healthy behaviors, which may occur *prior* to the first visit to the medical system. The seemingly passive and deferential patient behavior may be, in fact, the result of the patient’s conclusion that other health promotion strategies were ineffective and that now the provider should be in charge.

Likewise, patients’ beliefs about diseases often are ignored in the patient-provider interaction. Healthcare providers tend to view patient education and patient behavior change as a unidirectional process similar to traditional behavior modification approaches: an expert says what should be done (ie, smoking cessation) and negotiates strategies on how to achieve the objective. When these approaches are not effective, the provider may complain about noncompliant and passive patients. However, explanations about disease prevention and treatment recommendations are more likely to be ignored or misunderstood when they are not given in a context that makes sense to patients. Labeling patients as “not actively involved in their health maintenance” frequently means that the patients are not actively involved in the providers’ definition of health maintenance.<sup>28</sup> In contrast, a public health perspective on patient education strives to support healthy behaviors through community health education, media outreach, and community agency involvement.

#### Patients Should Be Empowered to Be Active Participants in Their Medical Care

The goal of changing patient behavior should extend beyond individual health behavior change toward a change in an individual’s negotiating behavior. In the case of a provider-patient partnership, the patient learns to express his or her opinions and negotiate action steps. The provider then can help the patient to apply these skills in interacting more effectively with the medical system. The medical system has cultural rules and norms that may be unfamiliar to patients coming from a different background than the provider. Immigrant and refugee patients who come from countries with different healthcare systems, for example, often are confused by the fragmented US healthcare

system. Information about the medical system has increased in importance as the shift toward managed care has caused the introduction of even more concepts and rules that may be new and unfamiliar to the consumer (eg, primary care provider, selection of health plans, preauthorization, copayment).

Patients also may be unaware that they are expected to participate. Teaching the patient about the culture of medicine also increases patients' competency to interact with the provider. Patients should know what kind of behavior the provider expects in the medical interaction. Depending on their prior experiences with the medical system, patients may have been discouraged from questioning a physician's authority, voicing opinions, or asking questions. It is important to let the patient know that these behaviors are now not only accepted but encouraged.<sup>29</sup>

If the patient decides to "let the physician be the guide," or to let a family member be the guide, that is the patient's choice. However, it is a true choice only after the patient is educated on the options for participatory care. In dealing with the medical system, patients may feel uncomfortable with an individualistic approach to medical decision making and may prefer a family member to act as a spokesperson. For example, an elder American Indian woman may prefer her daughter to speak for her because the daughter can better articulate the patient's concerns, or a Middle Eastern woman from a rural area may prefer her husband to communicate with the physician because he is supposed to represent the family to the outside world. The healthcare system has to accommodate these preferences.

If the patient learns how to navigate the medical system, it will improve more than access to care. It will also facilitate the patient's participation in quality assurance. A patient empowered to interact with the medical system knows his or her rights, and where and how to file complaints in case of discrimination and unsatisfactory care.

Some healthcare and teaching facilities have established lay medical schools or other training programs for underserved populations in order to address health disparities. The Center for Immigrant Health has developed patient empowerment tools that educate the community about the healthcare system, mechanisms for accessing it, and screening guidelines.<sup>30</sup> These training programs teach patients about the culture of medicine, as well as about lifelong preventive practices. This training could be formalized. First, necessary patient skills and knowledge should be defined. Federally funded training programs could be required to teach these skills effectively. These training programs then could be evaluated for their efficacy, effectiveness, and outcomes.

### **Providers Should Critically Evaluate Their Own Assumptions and Underlying Values About What Constitutes a "Good" Patient and Consider How These Assumptions and Values Affect Their Communication Strategies**

The ability to provide good healthcare is intimately tied to effective communication.<sup>17,31,32</sup> Western-trained practitioners may expect certain patient behaviors and may evaluate unfamiliar behaviors dismissively. For example, practitioners may expect patients to have a comfort level with extensive intake interviews, shared decision making, and behaviors Western medicine suggests to improve health. These behaviors may not be consistent with the consumer's past healthcare experiences and with cultural norms. For example, being outspoken may be considered rude by some cultures, or posing questions or concerns may be perceived as unwelcome.

Providers also need to be aware of their own values, attitudes, and biases, which could impact the provider-patient communication.<sup>33,34</sup> A variety of resource books challenge providers to question and expand their own assumptions, and identify perceptions and beliefs that impact the patient-provider interaction.<sup>35,36</sup> Without this self-awareness, important clues that would lead to the discussion of sensitive or difficult topics and better treatment may be missed.<sup>37</sup> Self-analysis and awareness also can be integrated into grand rounds and internal staff training. For example, the March 1999 Schwartz Center rounds sought to explore the influence of ethnic bias on the patient-provider interaction and the quality of healthcare delivery.<sup>38</sup> Using a current-affairs video clip and an interactive panel discussion, participants were encouraged to identify the often-subconscious racial prejudices that may undermine their relationships with patients; and staff members were challenged to think creatively about how institutions and individuals might promote "cultural competence" and a more equitable healthcare environment.<sup>38</sup>

Providers must ask themselves how much patient "noncompliance" they are ready to accept when the patient's decision is not consistent with the provider's value system. How would the provider react if the patient refuses to abstain from drinking alcohol despite serious health effects, decides to stay in an abusive relationship, or decides to become or stay pregnant despite grave medical risks? Is the provider ready to let go and to respect the decision of the consumer? Changing patient behavior thus is less about how to increase patient adherence, and more about how to provide patients with the tools and evidence to make informed choices, while respecting the patient's decisions.

Medical academic centers increasingly include cultural competence and provider self-awareness in their curricu-

la. Accreditation requirements for medical-education programs leading to a medical degree in the United States and Canada require that medical students and faculty demonstrate “an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.”<sup>38</sup> Medical schools must document “development of skills in cultural competence, indicate where in the curriculum students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.” Medical school instruction must stress “the need for students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on their health.” Clinical instruction is to include “demographic influences on health care quality and effectiveness, such as racial and ethnic disparities in the diagnosis and treatment of diseases.” Most importantly, “self-awareness among students regarding any personal biases in their approach to health care delivery” is to be addressed.

In 1999, the Accreditation Council for Graduate Medical Education identified 6 core competencies for physicians: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The fourth competency requires interpersonal and communication skills resulting in effective information exchange and collaboration with patients, their families, and other health professionals.<sup>39</sup> The fifth competency, professionalism, includes “sensitivity to a diverse patient population.”

In addition to these new accreditation standards, many organizations including the Institute of Medicine, the Maryland General Assembly, and the American Medical Association<sup>40</sup> encourage medical and graduate schools to provide training in culturally competent healthcare and health disparities. The Institute of Medicine recommended in *Unequal Treatment* that cross-cultural education should be integrated into the training of all current and future health professionals.<sup>41</sup> Maryland Code 90-201 encourages courses or seminars that address the identification and elimination of disparities in healthcare services for minority populations as part of the continuing-education requirements for healthcare providers and the continuing-education programs for hospital staff and healthcare practitioners.<sup>42</sup> Under this Maryland law, the Department of Health and Mental Hygiene, in consultation with the Maryland Healthcare Foundation, must develop and implement a plan to reduce healthcare disparities based on gender, race, ethnicity, and poverty. Specifications for a model course or seminar must be submitted to the governor by September 30, 2004.

### **The Patient's Behavior Change in the Medical Interaction Should Result from a Process of Negotiation Between Provider and Patient**

The medical provider does have standards of best treatment and advice to provide to the patient. However, changing patient behavior is not a simple matter of health education. Change is achieved by improving the patient-provider communication. The goal is participatory decision making, which integrates the patient's value system and opinions with the professional evidence. A culturally competent provider-patient interaction is a negotiation process between the provider's and the consumer's perception of what is appropriate in terms of both process and action.

Cultural-competence curricula present a variety of mnemonics that summarize the components of an effective provider-patient interaction, such as LEARN, developed by the Family Practice Residency at San José Health Center in San José, California.<sup>43</sup> LEARN stands for the following steps: *l*isten with sympathy and understanding, *e*xplain your perceptions of the problem, *a*cknowledge and discuss the differences and similarities, *r*ecommend treatment, and *n*egotiate agreement.

These guidelines for effective cross-cultural communication parallel the process described in effective adult education, which not only conveys knowledge but also enables the learner to induce system change. The popular education model, as developed by Freire, describes 3 stages of consciousness:<sup>44</sup> (1) listening, (2) dialogue, and (3) process, empowerment, conscious reflection, and action.

*Listening.* In their groundbreaking article on cross-cultural medical care, Kleinman et al suggested questions that encourage providers to listen closely to patients' stories.<sup>45</sup> By asking these questions, the provider can determine the patient's behavior prior to coming to the physician; the patient's primary agenda and major concern; the patient's explanatory model of the illness (ie, his or her understanding of the cause, severity, and prognosis of an illness); the treatment expected by the patient; how the illness affects his or her life; and his or her expectations of what should be done.<sup>45</sup> The healthcare provider has to learn how to frame questions that instill confidence and are non-threatening, and encourage patients to share their values and beliefs. It also is important to identify a patient's social context, which includes socioeconomic status, migration history, social networks, literacy, English fluency, and so forth. The listening process helps the patient to feel heard and validated. It is crucial that the provider learns to listen prior to making any conclusions or recommendations.

*Dialogue.* Freire suggests that a person can begin dialogue only after he or she has been heard. “How can I dialogue if I am closed to—and even offended by—the contribution of others?”<sup>44(p79)</sup> During this phase, the medical provider explains his or her perception of the problem. In discussing similarities and differences between the provider’s and the patient’s perception, it is important to validate the patient’s opinion. The provider does not have to agree with the patient’s perception. However, by acknowledging the patient’s belief model, the provider is expressing respect and opens the way to a dialogue.

*Process, Empowerment, Conscious Reflection, and Action.* In this third phase, the patient takes responsibility, control, and action. This phase parallels the provider’s treatment recommendation and the negotiation of a treatment plan. Negotiation of explanatory models involves acknowledgment of differences in belief systems between patient and provider, and reaching a compromise by presenting the problem in terms and concepts that reflect the patient’s explanatory model. For example, the provider could counter a patient’s resistance to taking medication on a regular basis for a chronic disease by building on the patient’s familiarity with the use of vitamins as way to remain healthy and energetic. Concurrence of explanatory models also should be noted and stressed by providers. For example, in a study of Latino adults’ beliefs about asthma, the ethnomedical concepts of “hot” and “cold” humors and the importance of balance were incorporated into the biomedical explanatory model of asthma.<sup>46</sup> By stressing this shared explanatory model, the provider can establish trust and emphasize other asthma information.

### **The Medical System Should Focus on Community Empowerment in Addition to Individual Empowerment**

Community change is a vehicle for changes in patient behaviors. The patient is part of the community, not merely an isolated individual. The community impacts patients’ ways of thinking and how they interact and express their concerns with the provider. Typically, the medical system reaches out to family members and to community members in the form of community health education and support groups. Often, these groups do not move to the next level of empowerment, which is the building of community capacity. Support groups can be used as a first step to bring resources together and to develop a mechanism for advocacy for institutional change. For example, when patients prefer their family members to be involved in medical decision making and to act as interlocutors with the medical system, groups of patients’ family members can advocate for them and

help them to navigate the system. Healthcare agencies that actively involve entire communities through intergenerational and familial strategies include Charles B. Wang Community Health Center, New York, New York, and the Caribbean Women’s Health Association, Brooklyn, New York.

Community input is vital from the earliest phases of program planning. This strategy requires identification and involvement of advisors and key informants who can act as cultural mediators. These community elders could be paired with outreach workers and clinical supervisors who know the institution, thus engaging in a dialogue and mutual learning process. One such program is Cultural Positivity, a joint venture of Golden Valley Health Centers and the Mercy Medical Center Merced Family Practice Residency Program sponsored by The California Endowment. Cultural mediators are located and nurtured to create a knowledgeable and welcoming environment for a diverse patient population.

Reaching out to the community has to be more than a token initiative. It must be a process. To reach diverse communities effectively, the communities’ expectations and knowledge about the healthcare system have to be assessed. Implementing a system that routinely asks for community input during program implementation is necessary (eg, an ombudsman system that is accessible to community members who have different backgrounds and whose input is used for program monitoring).

Advocacy is an important aspect of social justice, which concerns the extent to which societal conditions are fair and resource distribution is equal.<sup>47</sup> Advocacy is crucial to enable system change and to ensure the enforcement of mandates and regulations. For example, the pressure of community groups and immigrant advocacy groups played an important role in the improvement of access to quality medical interpretation for patients with limited proficiency in English (LEP). These advocacy efforts arose from the awareness that immigrants bear heavy burdens of ethnic and racial disparities in healthcare, and that language barriers can compromise both access to and quality of care for foreign-born patients.<sup>32</sup>

The consequences of miscommunication (eg, diagnostic errors, missed appointments, failure of patients to understand and adhere to treatment recommendations, failure of providers to obtain truly informed consent and to be sensitive to a patient’s own culturally derived understanding of health and illness) can be costly and severe. On a federal and sometimes on a state level, legal mandates for the provision of interpreter services in medical settings are being developed. For example, the Office of Minority Health, US Department of Health and Human Services, released

standards for culturally and linguistically appropriate services in healthcare.<sup>48</sup> However, few enforcement mechanisms at the local level enable advocates to monitor the implementation of medical interpreter services in their communities. To reduce health disparities as stipulated in *Healthy People 2010*, LEP patients should have universal access to real-time, remote-simultaneous, culturally sensitive interpretation systems by the year 2010. Achieving this objective will depend on the allocation of appropriate funding and reimbursement mechanisms. Community organization and advocacy enable the community to monitor whether (1) resources are being allocated to the development and evaluation of innovative interpreter banks and systems and (2) a strategic approach to civil rights enforcement of the right to interpretation is being developed and implemented at a national level.

Advocacy also can influence the community to take steps that protect its interest in access to healthcare. Changes in the healthcare system and improvements for the majority of the population may at times have a negative impact on subgroups. For example, the concept of universal access to healthcare threatens the treaty of Native Americans and weakens their ability to get quality healthcare. Native Americans are the only minority group in the United States that has to solicit healthcare funding directly from Congress. Eighty percent of the services provided by Indian Health Services in the territories are funded via Medicaid. However, if Native Americans use Medicaid outside of the territories, it decreases the funding for Indian Health Services and hence jeopardizes the delivery of quality medical care in the territories. This puts Native Americans in a double bind and prevents them from using timely health services outside of the territories. Community organization and advocacy might allow the Native American community to aspire to a health system that provides consistent quality care and respects treaty rights without penalty of fund transfer.

**Accessible and Understandable Outcome Data Will Empower the Community to Be Active Participants in the Elimination of Health Disparities**

Eliminating health disparities will require holding the medical system accountable. At every level of caregiving, outcomes data need to be collected by race/ethnicity, country of birth, length of residence, socioeconomic status, and language preference. These data will allow assessment of the gaps in health outcomes at a particular institution or health plan and measurement of the progress toward reduction of these health disparities.

These data have to be shared with the community in

a clear and understandable way. The community can then use the data to set an agenda and to advocate for program and system changes. The data also can serve as leverage for more equitable resource allocation and legislative changes (eg, legislation that requires agencies to employ lay health advisors who can act as intermediaries between the community and the medical culture). Lay health advisors could ensure community participation at all levels of the health promotion and service delivery process.

The federal government could use negotiations among Medicaid and Medicare reimbursement plans to require the involvement of the community in agenda-planning and monitoring outcome data. By asking for regular updates on progress toward eliminating health disparities at the local level, the federal government can indicate its expectation that a measurable effect will occur.

Most communities do not have the infrastructure necessary to integrate outcomes data information into an advocacy plan. The federal government can facilitate the creation of an appropriate structure through a grant program (eg, an Office of Minority Health bilingual and bicultural demonstration grant) that stimulates model development and conducts rigorous process and outcome evaluation of these models.

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**RECOMMENDATIONS**

What are the roles of patients and providers in the provider-patient interaction? How can we develop systems that empower patients, and how can we encourage patients to be actively involved in their treatment?

One possibility is to fund peer education initiatives that engage cultural mediators and translators in the healthcare settings. For example, Congress currently is considering legislation that would allocate grants for patient navigators, who would assist individuals belonging to minority groups in whom health disparities have been documented in receiving preventive and early-detection services for cancer and chronic diseases.

Workshop participants recommended a set of community-, school-, and church-based strategies to educate patients from racial, ethnic, and language minority groups. Potential curricula include functional health literacy, navigating encounters with the healthcare system, patient negotiating behavior, techniques for maintaining personal healthcare records, and patient's rights (including the right to linguistically appropriate services). Unlike typical patient education programs, these curricula would focus on increasing the patients' awareness of the US healthcare system, the medical culture, their providers' expectations of them, and their rights to access healthcare. These curricula should be

disseminated widely through the ethnic media and community-based institutions, including community organizations, faith-based organizations, and English-as-a-second-language (ESL) programs. Healthcare facilities also could facilitate the creation of local patient support groups that empower patients in their interactions with healthcare providers.

Bridging the language gap is crucial for improvement of provider-patient communication. Funding of ESL classes needs to be adequate to prevent waiting lists of individuals eager to learn the language. For LEP patients, language-concordant and quality interpreting services have to be available, when needed, so that patients “stand a chance” of being heard and of hearing the provider. This perspective requires a new paradigm that views the provision of culturally and linguistically appropriate healthcare services as a civil right. Congress could implement this policy by approving federal legislation that funds grants and demonstration projects that include cultural-competency training in medical education. State-based associations and patient advocates, with the involvement of the patients themselves, should lobby for Medicaid reimbursement of translation services.

Cultural-competence curricula should be integrated into both medical training and continuing medical education. The Joint Commission on Accreditation of Healthcare Organizations, state boards of medical examiners, licensing boards, and other certifying and accreditation organizations should require cultural-competence training as an integral part of continuing medical education and related health education programs for licensed physicians and other practicing health personnel. The Association of American Medical Colleges, other national professional associations, state accrediting bodies, and state commissions on higher education should continue to require training in culture competency as an integral part of the curricula for medical and dental students, and other health professionals.

Data on health disparities and barriers to services are crucial to designing informed services and outreach programs. State and local campaigns can raise public awareness (the level of “critical consciousness”) of communication and healthcare issues, building on the Health Resources and Services Administration’s “100% Access/Zero Disparities” demonstration programs. Highlighting disparities in health status and patient outcomes for members of racial and ethnic minority groups would be especially useful in raising awareness. Large, publicly funded state managed care organizations for Medicare and Medicaid patients, as well as all practitioner organizations and community hospitals receiving federal funds, should be required to collect data to mon-

itor the outcomes of cultural-competence training as part of their quality assurance programs. For example, has this training improved the knowledge, skills, and attitudes of staff practitioners? Has it changed patient satisfaction levels?

These 6 principles promote consumers’ active involvement in their health and disease management, and facilitate the involvement of community agencies and mediators in addressing healthcare gaps. This involvement in turn will facilitate ongoing and sustainable efforts to reduce health disparities at the local, state, and national levels.

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